

Unannounced Care Inspection Report 13 and 14 June 2016



Corriewood Private Clinic

Type of Service: Nursing Home
Address: 3 Station Road, Castlewellan
Tel No: 0284377 8230
Inspector: Bridget Dougan

1.0 Summary

An unannounced inspection of Corriewood Private Clinic took place on 13th June 2016 from 12.00 to 16.30 and 14th June 2016 from 10.30 to 16.30 hours.

The inspection sought to assess progress with issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of positive outcomes for patients who were being assisted and responded to in a timely and dignified manner. The home was found to be warm, fresh smelling and clean throughout.

Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their role, function and responsibility. There was evidence of a structured orientation and induction for newly appointed staff and competency and capability assessments for registered nurses.

Feedback provided by staff, patients and/or their representatives was generally very positive. One patient expressed some dissatisfaction with the current staffing levels. This was discussed with the manager who agreed to follow up the issues.

There were systems in place for the safe recruitment and selection of staff. There was evidence of a structured orientation and induction for newly appointed staff and mandatory training had been completed and was up to date for all staff. Competency and capability assessments had been completed for all registered nurses.

There were no requirements or recommendations made.

Is care effective?

Care records evidenced that registered nurses assessed, planned, evaluated and reviewed patients' care in accordance with professional guidelines.

There was evidence that the care planning process included input from patients and/or their representatives, as appropriate.

Staff stated that there was effective teamwork in the home; each staff member knew their role, function and responsibilities. Staff meetings were held on a regular basis (at least quarterly) and records were maintained.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

There were no requirements or recommendations made.

Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely.

Observation of the lunch time meal confirmed that patients were given a choice in regards to food and fluid choices, and the level of help and support requested.

Discussions with staff, relatives and patients and a review sample of compliment cards evidenced that staff cared for the patients and their representatives in a kind, caring and thoughtful manner.

There were no requirements or recommendations made.

Is the service well led?

There was a clear organisational structure within the home and evidence that the home was operating within its registered categories of care.

Complaints were managed in accordance with legislation. Notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There was evidence of an audit schedule and that a range of audits had been completed on a monthly basis, for example audits of accident/incidents, care records, wound care and complaints. The results of these audits had been analysed and appropriate actions taken to address any shortfalls identified. A recommendation was made for more frequent infection prevention and control audits to be carried out.

Monthly monitoring visits in respect of Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005 were completed as required. An action plan was generated to address any areas for improvement and reviewed on subsequent monitoring.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health (DOH) Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Imelda McGrady, responsible person, Ms Teresa Josephine McClean, registered manager and Ms Marie McGrady, Director, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent medicines management inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 6th June 2016. Other than those actions detailed in the previous QIP there were no further actions required. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered provider: Corriewood Private Clinic Mrs M.I. McGrady Mrs Anne Monica Byrne	Registered manager: Ms Teresa Josephine McClean
Person in charge of the home at the time of inspection: Mrs Imelda McGrady (Day 1) Ms Teresa Josephine McClean (Day 2)	Date manager registered: 01/04/2005
Categories of care: NH-LD, NH-LD(E), NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE, NH-MP	Number of registered places: 63

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection we met with forty patients, four registered nurses, twelve care staff, one catering, one laundry and one domestic staff.

Ten patients, eight staff, and four relatives' questionnaires were left for distribution.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- six patient care records
- staff training planner for 2016/17
- two staff personnel records
- accident and incident records
- notifiable events records
- sample of audits
- complaints and compliments records
- NMC and NISCC registration records
- staff induction records
- nurse competency and capability assessments
- minutes of staff meetings

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 6 June 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was not due to be returned at the time of this inspection.

There were no issues required to be followed up during this inspection and any action taken by the registered providers, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 22 February 2016

Last care inspection statutory requirements		Validation of compliance
No requirements were made		
Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 13.4 Stated: Second time To be Completed by: 22 April 2016	The registered manager must ensure that the programme of activity is displayed in a format suitable to meet the needs of patients, for example, a pictorial format could be considered. Reference: Section 5.1	Met
	Action taken as confirmed during the inspection: A programme of activities was displayed in pictorial format on the activity board in each of the units.	

Recommendation 2 Ref: Standard 32 Stated: First time To be Completed by: 30 June 2016	The registered manager should provide update training on palliative and end of life care for all care staff relevant to their roles and responsibilities Reference: Section 5.3	Met
	Action taken as confirmed during the inspection: The majority of care staff attended training on palliative and end of life care on 28 April 2016.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing rotas for the weeks commencing, 30th May, 6th June and 13th June 2016 evidenced that the planned staffing levels were adhered to.

All patients, patients' representatives and the majority of staff felt there was enough staff to meet the needs of the patients. One staff member felt there was not enough staff at times. This was discussed with the registered manager following the inspection.

Observations of the delivery of care evidenced that patients were being assisted and responded to in a timely and dignified manner.

Discussion with the registered manager confirmed that there were systems in place for the safe recruitment and selection of staff, and staff consulted confirmed that they had only commenced employment once all the relevant checks had been completed. Two staff personnel files were viewed and we were able to evidence that all the relevant pre-employment checks had been completed.

Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment.

Review of the training matrix/schedule for 2016/17 indicated that training was planned to ensure that mandatory training requirements were met. There was also evidence that mandatory training had been completed by all staff in 2015. Discussion with the manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training.

Staff clearly demonstrated the knowledge, skills and experience necessary to fulfil their role, function and responsibility.

There was evidence of competency and capability assessments completed for registered nurses. The manager also had a planner for staff supervision and appraisals.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home’s policies and procedures. RQIA were notified appropriately.

Review of six patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Discussion with the registered manager confirmed that a range of audits was conducted on a regular basis (refer to section 4.6 for further detail). A sample of falls audits confirmed the number, type, place and outcome of falls. This information was analysed to identify patterns and trends. An action plan was in place to address any deficits identified.

A review of the accident and incident records confirmed that Trust care management, patients’ representatives and RQIA were notified appropriately.

We observed the environment, including a sample of bedrooms, bathrooms, lounges, dining room and storage areas. The home was found to be warm, fresh smelling and clean.

Fire exits and corridors were observed to be clear of clutter and obstruction and equipment was appropriately stored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0
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4.4 Is care effective?

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements.

Review of six patient care records evidenced that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines.

Staff demonstrated an awareness of the importance of contemporaneous record keeping and of patient confidentiality in relation to the storage of records.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

Discussion with staff and a review of the duty rota evidenced that nursing staff were required to attend a handover meeting at the beginning of each shift. Care staff received a safety briefing by the nurse in charge of each unit at the start of each shift. This was reported to be working well.

Discussion with staff and the registered manager confirmed that staff meetings were held on a regular basis (at least quarterly) and records were maintained.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and their representatives expressed their confidence in raising concerns with the home's staff/management.

Areas for improvement

No areas for improvement were identified during the inspection

Number of requirements	0	Number of recommendations:	0
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4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely.

Observation of the lunch time meal confirmed that patients were given a choice in regards to food and fluid choices, and the level of help and support requested. Staff were observed to offer patients reassurance and assistance appropriately.

The daily menu was displayed in the dining rooms and offered patients a choice of two meals for lunch and dinner. A choice was also available for those on therapeutic diets. Patients all appeared to enjoy their lunch.

Discussions with staff confirmed that they had a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan.

Patients spoken with commented positively in regards to the care they received and life in the home. Those patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives and staff on the quality of the service provided. Views and comments recorded were analysed and areas for improvement were acted upon.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. From discussion with the registered manager, staff, relatives and a review of the compliments records, there was evidence that the staff cared for the patients and the relatives in a kindly manner.

As part of the inspection process, we issued questionnaires to staff, patients and their representatives. Seven patients, four patients' representatives and eight staff completed questionnaires. Some comments are detailed below.

Staff

- "I love working here. The patients are all very well looked after"
- "this is a very good home. I have no concerns about staffing levels"
- "we could be doing with a few more staff"
- "this is a very nice place to work"

The comment received from one staff member regarding staffing levels was followed up with the registered manager at the conclusion of the inspection as discussed in section 4.3.

Patients

Comments received from patients were very positive. No concerns were expressed. The following is a sample of the comments received from patients:

- "staff treat us with dignity and respect"
- "everything is very good"
- "I can't think of anything that needs improved"
- "I'm very happy here. The staff are all very good"
- "the food is good"

Patients' representatives

The following comments were received from patients' representatives:

- "I am absolutely delighted with this home. The management and staff are second to none. They go out of their way to care for patients and other families"

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations:	0
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4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were knowledgeable in regards to their roles and responsibilities. Staff also confirmed that there were good working relationships and that the management were responsive to any concerns raised.

The certificate of registration issued by RQIA was displayed in the home.

A certificate of public liability insurance was current and displayed.

Discussion with the registered manager, a review of care records and observations confirmed that the home was operating within its registered categories of care.

Review of the home's complaints record and discussion with the registered manager evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

There were systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

There was evidence that a range of audits had been completed on a monthly basis, including care records, accidents/incidents, wound care, complaints, catering and laundry. Hand hygiene audits were completed on a regular basis and comprehensive infection prevention and control audit was completed annually. It is recommended that infection prevention and control audits are completed on a regular basis.

The results of the above audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvements had been embedded into practice.

The monthly monitoring visits required in regard to Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005 were completed in accordance with the regulations. An action plan was generated to address any areas for improvement.

A discussion with the registered manager and a review of records confirmed there were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Areas for improvement

Infection prevention and control audits should be completed on a regular basis and the findings of these audits should be regularly shared with staff, patients, relatives and visiting professionals as appropriate. There should be evidence that actions have been taken to address any deficits and improvements have been embedded into practice.

Number of requirements	0	Number of recommendations:	1
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Imelda McGrady, responsible person, Ms Teresa Josephine McClean, registered manager and Ms Marie McGrady, Director, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises, RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to nursing.team@rqia.org.uk for review by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations

Recommendation 1

Ref: Standard 46.2

Stated: First time

To be completed by:
31 August 2016

The registered provider should ensure that infection prevention and control audits are completed on a regular basis and the findings of these audits should be regularly shared with staff, patients, relatives and visiting professionals as appropriate. There should be evidence that actions have been taken to address any deficits and improvements have been embedded into practice.

Reference: Section 4.6

Response by registered provider detailing the actions taken:

A monthly infection control audit is now in place for each suite. An action plan will be completed and shared with staff using the same system as all other monthly audits. Any improvements to be made will be embedded into practice.



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